UNION HOSPITAL
AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Union Hospital
659 Boulevard
Dover, Ohio, 44622
Phone: 330-343-3311 ext. 2326

Patient's Name: _____
Date of Birth: _____
Date of Treatment: _____
Soc. Sec. Number: _____
MR # / Acct. #: _____

1. I hereby authorize and give my consent to permit:

_____

_____

to examine or receive a copy of records indicated below including diagnosis, HIV testing, care and treatment of AIDS related condition, drug/alcohol abuse and/or psychiatric/mental conditions:

- ☐ DISCHARGE SUMMARY
- ☐ HISTORY AND PHYSICAL
- ☐ OPERATIVE REPORTS
- ☐ PATHOLOGY REPORTS
- ☐ RADIOLOGY REPORTS
- ☐ X-RAY FILM
- ☐ LABORATORY REPORTS
- ☐ CARDIOPULMONARY REPORTS
- ☐ PHYSICIAN'S ORDERS/PROGRESS NOTES
- ☐ CONSULTATION REPORTS
- ☐ OTHER: _____
- ☐ COMPLETE MEDICAL RECORD (do not check this unless entire record is required)

2. The above information is released for the following purpose and that purpose only. Any other use is forbidden:

_____ Insurance or other third party reimbursement
_____ Continuity of medical care
_____ Pending legal action
_____ Other (specify) _____

3. A copy of this authorization made by duplicating process shall be valid for all purposes as this original signed by me. I understand that the release form must be dated not more than sixty (60) days before the date on which it is submitted.

4. I was informed of the State of Ohio record fees _____ Initials.

BY SIGNING BELOW I CERTIFY THERE IS NO COURT ORDER IN EFFECT WHICH LIMITS OR PROHIBITS MY ACCESS TO THESE RECORDS.

_____ _____ _____
(Signature) (Date) (Time)

Relationship: Self ☐ Spouse ☐ Guardian ☐ Other: _____

A legal document naming guardian or executor of estate must accompany authorization where applicable (proof of legal executor of estate of those patients expired, or legal proof of guardianship).

PLEASE ADDRESS YOUR CORRESPONDENCE TO: "HEALTH INFORMATION MANAGEMENT"

Please be advised:
The Medical Record is a combination of the printed electronic format and the handwritten forms.

Submit